vera
WHOLE HEALTH

Health History Questionnaire

Name:	DOB:
Who is completing this form? □ Self □ Other (please specify name and relationship)	
Contact Phone:	Gender:
Pharmacy:	Current Occupation:
Primary Care Provider:	Date of Last Physical/Wellness Exam:

Current Medications: Please be sure to include ALL kinds of medications such as prescription medications, vitamins, herbal medication, and supplements.

□ I take no prescription medications, non-prescription medications or other medications

Name of Medication	Dosage	When do you take it?
1.		
2.		
3.		
4.		
5.		

Allergies to medications? □ I have no known allergies

Drug	Reaction

Past Medical History: □ None

Surgeries/Hospitalizations: □ None

Year	Reason	Hospital

Health Maintenance: Please include year if known

□ Tetanus (Tdap)	□MMR	□ Chickenpox	□ Pap smear	□ PSA (prostate test)
□ Hepatitis B	□ HPV	□ Shingles	□ Mammogram	□ Colon cancer screen
□ Pneumonia	□ Flu		□ Bone density (DEXA)	

Women's Health:

First day of your last period?	Are your periods regular?
Do you have any concerns about your periods?	
Do you desire contraception or a change in contraception?	
Have you ever been pregnant?	

What are your concerns today? _____

_____

_____

_____

Continued on next page

vera
WHOLE HEALTH

Social History

Tobacco Use	**Do use tobacco products?** □Yes □No □Formerly □Current daily smoker, ____ (#) cigarettes/day □Vape or other form of nicotine _____
Alcohol Use	**Do you drink alcohol?** □Yes □No □Formerly How often? □Daily □Weekly □Occasionally How many drinks do you consume on average? _____ Do you feel like you have a problem with alcohol? □Yes □No □Maybe
Caffeine Use	**Do you consume caffeine?** □No □Yes: Type? _____ Cups per day? _____
Activity Level	**Average activity level?** □Sedentary □Moderate □Vigorous Type(s) of exercise: _____ Exercise Frequency □Daily □2-3 days/week □ 3-4 days/week □Occasionally □Never
Sleep	How many hours do you sleep each night? _____ Do you have trouble falling asleep? □Yes □No / Do you have trouble staying asleep? □Yes □No Do you take medication to help with sleep? □Yes □No □Sometimes Do you snore or stop breathing? □Yes □No
Firearms	Do you store firearms at home? □Yes □No If yes, are they stored both unlocked and unloaded? □Yes □No
Recreational Drug Use	□No history of use □Use or have used Type(s):_____
Safety	**Do you feel safe in your home?** □Yes □No □Sometimes **Do you feel safe in your relationship?** □Yes □No □Sometimes
Sexual History	**Are you sexually active?** □Yes □No □Formerly Number of current partners_____ Have you had sex with a □Man □Woman □Both Do you use condoms to protect against STIs? □Yes □No □Sometimes Do you use birth control? □Yes □No □Sometimes. Type? _____

Family History

Has any family member had:		Relationship	Age of Onset	Cause of death?
High Blood Pressure	□Yes □No □Unknown			
High Cholesterol	□Yes □No □Unknown			
Stroke	□Yes □No □Unknown			
Heart Attack	□Yes □No □Unknown			
Diabetes	□Yes □No □Unknown			
Colon Cancer	□Yes □No □Unknown			
Ovarian Cancer	□Yes □No □Unknown			
Breast Cancer	□Yes □No □Unknown			
Other Cancer (type_____)	□Yes □No □Unknown			
Mental Illness	□Yes □No □Unknown			
Substance Abuse	□Yes □No □Unknown			

Depression and stress:

Is stress a major problem for you? □Yes □No	Do you feel anxious most of the time? □Yes □No
Over the last 2 weeks, how often have you had a little or no interest in daily activities? □Not at all □Several days □More than half the days □Nearly every day	
Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless? □Not at all □Several days □More than half the days □Nearly every day	

_____

Patient signature (or Parent/Legal Guardian if under 18) **Date**